Medicaid Eligibility Handbook
Worksheet Section

MEDICAID INSTITUTION DETERMINATION WORKSHEET

Primary Person Name	Social Security Number

			Certify From_____ To_____ New Recertification Change Date_____ Worker_____	Certify From_____ To_____ New Recertification Change Date_____ Worker_____	Certify From_____ To_____ New Recertification Change Date_____ Worker_____
1	ENTER	Nonexempt Assets			
2	ENTER	Personal Allowance			
3	ENTER	Health Insurance Cost			
4	ENTER	Institutional Care Cost			
5	ENTER	Other Medical Costs			
6	ENTER	Support Obligation			
7	ENTER	Work Related Expenses			
8	ENTER	Court Ordered Attorney & Guardianship Fees			
9	ENTER	Expenses for Establishing & Maintaining Court Ordered Guardianship or Protective Placement			
10	ADD 2 THROUGH 9. THE RESULT IS TOTAL MONTHLY NEED.				
11	ENTER	Gross Earned Income			
12	ENTER	Total Unearned Income From Relative			
		All Other			
13	ADD 11 & 12. THE RESULT IS TOTAL GROSS MONTHLY INCOME				
14	ENTER	$65 + ½ of his/her gross earnings			
15	ENTER	Personal Allowance			
16	ENTER	Health Insurance Cost			
17	ENTER	Actual Support			
18	ENTER	Home Maintenance			
19	ENTER	Court Ordered Attorney & Guardianship Fees			
20	ENTER	Expenses for Establishing & Maintaining Court Ordered Guardianship or Protective Placement			
21	ADD	Lines 14-20			
22	SUBTRACT 21 FROM 13. THE RESULT IS INCOME AVAILABLE TOWARD COST OF CARE.				

(R.07/02) **RETAIN COMPLETED FORM IN CASE RECORD**